FACT SHEET

Federally Qualified Health Center

THE FEDERALLY QUALIFIED HEALTH CENTER (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. Medicare pays FQHCs, which are considered suppliers of Medicare services, an all-inclusive per visit amount based on reasonable costs with the exception of psychological or psychiatric therapeutic services. All therapeutic services furnished by clinical social workers (CSW) and clinical psychologists (CP) are subject to the outpatient mental health treatment limitation. This limit does not apply to diagnostic services.

Federally Qualified Health Center Designation

An entity may qualify as an FQHC if it is:

- Receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;
- Not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services to meet the requirements for receiving such a grant (i.e., qualifies as a FQHC look-alike) based on the recommendation of the Health Resources and Services Administration; or
- Operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Covered Federally Qualified Health Center Services

Payments are made directly to the FQHC for covered services furnished to Medicare patients. Services are covered when furnished to a patient at the FQHC, the patient's place of residence, or elsewhere (e.g., at the scene of an accident). A FQHC generally provides the following services:

- Physicians' services;
- Services and supplies incident to the services of physicians;
- Services of nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM), CPs, and CSWs;
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs;
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has determined that a shortage of home health agencies exists;

- Otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the FQHC; and
- Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease (effective for services furnished on or after January 1, 2006).

FQHCs also provide preventive primary health services when furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW. The following preventive primary health services are covered when furnished by FQHCs to Medicare patients:

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Well child care including periodic screening;
- Immunizations including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;
- Dipstick urinalysis; and
- Risk assessment and initial counseling regarding risks.

For women only:

- Prenatal and post-partum care;
- Prenatal services;
- Clinical breast examination;
- Referral for mammography; and
- Thyroid function test.

Federally Qualified Health Center Preventive Primary Services that are NOT Covered

FQHC preventive primary services that are NOT covered include:

- Group or mass information programs, health education classes, or group education activities including media productions and publications; and
- Eyeglasses, hearing aids, and preventive dental services.

Items or services that are covered under Part B, but are NOT FQHC services include:

- Certain laboratory services;
- Durable medical equipment, whether rented or sold including crutches, hospital beds, and wheelchairs used in the patient's place of residence;
- Ambulance services;
- The technical component of diagnostic tests such as x-rays and electrocardiograms;
- The technical component of the following preventive services:
  - Screening pap smears and screening pelvic examinations;
  - Prostate cancer screening;
  - Colorectal cancer screening tests;
  - Screening mammography; and
  - Bone mass measurements;

- Prosthetic devices that replace all or part of an internal body organ including colostomy bags, supplies directly related to colostomy care, and the replacement of such devices; and
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes including replacements (if required because of a change in the patient's physical condition).

Federally Qualified Health Center Payments

Under Original Medicare, each FQHC is paid an all-inclusive per visit rate based on its reasonable costs as reported in the annual Medicare FQHC cost report, with the exception of therapeutic services furnished by CSWs and CPs, which are subject to the outpatient mental health treatment limitation. This limit does not apply to diagnostic services. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the all-inclusive encounter rate.

The FQHC all-inclusive visit rate is calculated, in general, by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. The FQHC payment methodology includes two national per-visit payment limits—one for urban FQHCs and one for rural FQHCs. For services furnished on or after January 1 of each year, the two national per-visit payment limits are increased by the Medicare Economic Index applicable to primary care physician services. A FQHC is designated as an urban or rural entity based on definitions in Section 1886(d)(2)(D) of the Act. If a FQHC is not located within a Metropolitan Statistical Area or New England County Metropolitan Area, it is considered rural and the rural limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services including FQHC direct costs, any shared costs applicable to the FQHC, and the FQHC's appropriate share of the parent provider's overhead costs. Form CMS-222-92 can be found at **www.cms.hhs.gov/CMSForms/CMSForms/list.asp** on the CMS website.

Provider-based FQHCs must complete Worksheet M of Form CMS-2552-96, Hospital Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services. At the beginning of the rate year, the Fiscal Intermediary calculates an interim all-inclusive visit rate based on either estimated allowable costs and visits from the FQHC if it is new to the FQHC Program or on actual costs and visits from the previous cost reporting period if it is not new. The FQHC's interim all-inclusive visit rate is reconciled to actual reasonable costs at the end of each cost reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual—Part 2 (Pub. 15-2), Chapter 36, which can be found at **www.cms.hhs.gov/Manuals/PBM/list.asp** on the CMS website.

The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report to report the cost of these vaccines and related administration. These costs should never be reported on the claim when billing for FQHC services. There is no coinsurance or deductible for these services; therefore, when these vaccines are administered, the charges for the vaccines and related administration are never included with the visit charges when calculating coinsurance or deductible for the visit. When a FQHC physician, PA, NP, or CNM sees a beneficiary for the sole purpose of administering these vaccinations, the FQHC may not bill for a visit; however, the associated costs should still be included on the annual cost report.

The cost of the Hepatitis B vaccine and related administration are covered under the FQHC's all-inclusive rate. If other services that constitute a qualifying FQHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the

vaccine and related administration can be included in the charges for the visit when billing and in calculating the co-insurance and/or deductible. When a physician, PA, NP, or CNM sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, he or she may not bill for a visit; however, the associated costs should still be included on the annual cost report. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent FQHC visit and in calculating the coinsurance and/or deductible.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005 by physicians, PAs, NPs, and CPs who are affiliated with FQHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if furnished by individuals not affiliated with FQHCs.

HELPFUL RURAL HEALTH WEBSITES

CENTERS FOR MEDICARE & MEDICAID SERVICES' WEBSITES

CMS Forms
www.cms.hhs.gov/CMSForms/CMSForms/list.asp

CMS Mailing Lists
www.cms.hhs.gov/apps/mailinglists

Critical Access Hospital Provider Center
www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Provider Center
www.cms.hhs.gov/center/fqhc.asp

Hospital Provider Center
www.cms.hhs.gov/center/hospital.asp

HPSA/PSA (Physician Bonuses)
www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Internet-Only Manuals
www.cms.hhs.gov/Manuals/IOM/list.asp

Paper-Based Manuals
www.cms.hhs.gov/Manuals/PBM/list.asp

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate/MMU/list.asp

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Rural Health Center
www.cms.hhs.gov/center/rural.asp

Telehealth
www.cms.hhs.gov/Telehealth

OTHER ORGANIZATIONS' WEBSITES

American Hospital Association Section for Small or Rural Hospitals
www.aha.org/aha/key_issues/rural/index.html

Government Printing Office—Code of Federal Regulations
www.gpoaccess.gov/cfr/index.html

Health Resources and Services Administration
www.hrsa.gov

National Association of Community Health Centers
www.nachc.org

National Association of Rural Health Clinics
www.narhc.org

National Rural Health Association
www.nrharural.org

Rural Assistance Center
www.raconline.org

U.S. Census Bureau
www.census.gov

Medicare Contracting Reform (MCR) Update
Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of DME claims and one A/B MAC (Jurisdiction 3) to handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at **www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

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